ATTENDING DENTIST'S STATEMENT

UNITED CONCORDIA
America's Premier Dental Insurer

Check One

- ❑ Dentist's pre-treatment estimate
- ❑ Dentist's statement of actual services

Please submit claim to: Dental Claims
P.O. Box 69421
Harrisburg, PA 17106-9421

PATIENT SECTION

1. Patient name	2. Relationship to employee (self / spouse / child / other)	3. Sex (m / f)	4. Patient birthdate (mo / day / year)	5. If full time student (school / city)

6. Employee/subscriber name (First / middle / last)	9. Contract ID # or SSN
8. Employee/subscriber mailing address City, State, Zip	10. Employer (company) name and address

11. Group Number	12. Location (Local)	13. Are other family members employed? (Employee name / Soc. sec. no.)	14. Name and address of employer in item 13

15. Is patient covered by another dental plan?	Dental plan name	Union local	Group no.	Name and address of carrier

I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.

Signature (patient or parent if minor) _____ Date _____

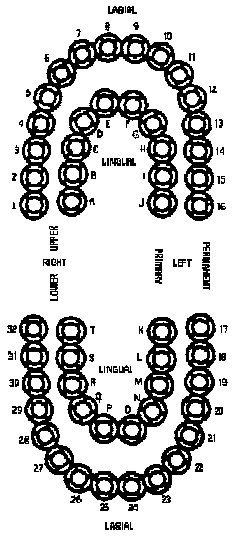
I hereby authorize payment directly to the below name dentist of the group insurance benefits otherwise payable to me.

Signature (insured person) _____ Date _____

DENTIST SECTION

16. Dentist name	24. Is treatment result of occupational illness or injury?	No	Yes	If yes, enter brief description and dates
17. Mailing address City, state, zip	25. Is treatment result of auto accident?			
	26. Other accident?			
	27. Are any services covered by another plan?			
18. Dentist soc. sec. or T.I.N. 19. Dentist license no. 20. Dentist phone no.	**28. If prosthesis, is this initial placement?**			**(If no, reason for replacement)** **29. Date of prior placement**
21. First visit date current series 22. Place of treatment (Office / Hosp. / ECF / Other) 23. Radiographs or models enclosed? (No / Yes / How Many?)	30. Is treatment for orthodontics?			If services already commenced enter Date appliances placed Mos. treatment remaining

Identify missing teeth with "X"



32. Remarks for unusual services

31. Examination and treatment plan-list in order from Tooth No. 1 through Tooth No. 32 - Use charting system shown. Use charting system shown

TOOTH NO. OR LETTER	SURFACE	DESCRIPTION OF SERVICES (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED,ETC.) LINE NO.	DATE SERVICE PERFORMED MO.	DAY	YR.	PROCEDURE CODE	FEE	FOR ADMINISTRATIVE USE ONLY

I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

Signature (Dentist) _____ Date _____

TOTAL FEE CHARGED	
MAX ALLOWABLE	
DEDUCTIBLE	
CARRIER %	
CARRIER PAYS	
PATIENT PAYS	

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.